

MDR Tracking Number: M5-04-2698-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on April 26, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits rendered on 5/8/03 and 6/10/03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the office visits rendered on 5/8/03 and 6/10/03.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 5/8/03 and 6/10/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 22nd day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

Enclosure: IRO decision

October 13, 2004

Ms. Rosalinda Lopez
Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

**NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination**

**RE: MDR Tracking #: M5-04-2698-01
TWCC #:
Injured Employee:
Requestor: Albert C. Molnar, M.D.
Respondent: SORM
MAXIMUS Case #: TW04-0249**

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the MAXIMUS external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation and is familiar with the condition and treatment options at issue in this appeal. The MAXIMUS physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on _____. The treating diagnoses for this patient includes adhesive capsulitis of shoulder and sprain/strain of the lumbar region. A physical medicine office note dated 7/17/03 indicated that the patient had not received any treatment for her work related injury since 10/29/02. The patient presented to the treating doctor's office on 5/8/03 with complaints of back pain with raising of her legs and decreased sensation noted over the right lateral foot. The patient was referred for an MRI of the lumbar spine. A follow up office visit note dated 6/10/03 indicated that the Carrier had denied

coverage for the MRI and that the patient would be treated with sample medications. It also indicated that the impression for this patient were unstable back injury – back pain with HNP.

Requested Services

Office visit 5/8/03 and CPT 99214 on 6/10/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Office Visit Note 5/8/03 and 6/10/03
2. Subsequent Report 5/8/03 and 6/10/03

Documents Submitted by Respondent:

1. Physical Medicine Office Note 7/17/03
2. Same as above

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The MAXIMUS physician reviewer noted that this case concerns a female who sustained a work related injury on _____. The MAXIMUS physician reviewer also noted that the patient has experienced ongoing low back, right buttock/hip pain, and radicular symptoms in the right lower extremity. The MAXIMUS physician reviewer indicated that the patient had been treated with different modalities for her right hip, buttock, and low back pain that included facet injections. The MAXIMUS physician reviewer noted that the patient's condition had been aggravated after the patient had been involved in 2 separate motor vehicle accidents in 1999. The MAXIMUS physician reviewer explained that although the patient had continued back pain and radicular symptoms, she did not seek much treatment for these symptoms after 3/2001. The MAXIMUS physician reviewer indicated that the patient presented for an office visit on 5/8/03 for complaints of persistent back pain that was not being controlled with Ibuprofen any longer. The MAXIMUS physician reviewer noted that certain recommendations were made for this patient's back pain and that a requested MRI for reevaluation was denied. The MAXIMUS physician reviewer indicated that the patient returned to the treating physician on 6/10/03 for continued treatment and evaluation of her persistent back and lower extremity pain. The MAXIMUS physician reviewer explained that the office visits on 5/8/03 and 6/10/03 were medically necessary for treatment and evaluation of persistent back pain with possible radicular symptoms. Therefore, the MAXIMUS physician consultant concluded that the office visit on 5/8/03 and CPT code 99214 on 6/10/03 were medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department